PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Paediatricians' Attitudes and Beliefs toward Transgender People- A Cross-Sectional Survey in Israel
AUTHORS	Landau, Nitsan; Hamiel, Uri; Tokatly Latzer, Itay; Mauda, Elinor; Levek, Noah; Tripto Shkolnik, Liana; Pinhas-Hamiel, Orit

VERSION 1 – REVIEW

REVIEWER	Gary Butler UCLH England Chair, Gender Dysphoria Working Group,European Society for Paediatric Endocrinology. Clinical lead in endocrinology, National Gender Identity Development Service
REVIEW RETURNED	28-May-2019

GENERAL COMMENTS	This is an interesting and helpful study beginning to unpick reasons for discomfort in dealing with transgender persons. It focussed on paediatricians as that was the accessible group, but it may well be interesting to explore other groups. The survey asked about personal beliefs and ideologies but not with the actual influence on clinical practice. It is a straightforward, honest account of the study performed and the study is well conducted, and the paper is well presented (other than US spelling). Studies like these do help stimulate the debate in this area and highlight the need for better education of doctors. I was surprised some of the highly significance values reported in table 1 with identical median values. Please could they be confirmed. I would be happy with this paper as it stands (with minor clarification to the editor) but papradoxically it is an editorial decision as to whether the journal wishes to extend the debate in this area. This is an open review so the editor should be aware I published a factual educational article in a BMJ family journal last year (ADC) so this, in my view is complimentary.

REVIEWER	Professor Damien W Riggs Flinders University Australia
REVIEW RETURNED	31-May-2019

GENERAL COMMENTS	1) The abstract and introduction require greater nuance. Yes, in general transgender children experience poorer outcomes compared to cisgender peers, but not when they are affirmed in their gender, particularly by families. Recent research by Olson and colleagues

	has found very similar outcomes for transgender and cisgender young people when the former are affirmed. 2) 'Female' and 'male' are sex-based categories: preferable to use 'women' and 'men' throughout. Was there no question asking if participants were transgender or cisgender? This seems a significant oversight. 3) There are problems with English expression in the article summary 4) There is a leap in lines 50-57 from poor outcomes (though see 1 above) to pediatricians' role. The two are not automatically or logically connected. 5) The next paragraph then does not follow on: what progress? How does this relate to the previous paragraph? 6) The alpha value for the TABS should be reported in regards to the present study (or better still, for each sub scale) 7) I wasn't convinced by the justification for translating the TABS into a categorical measure. Has this been done before? Having one point as favourable and all other points as unfavourable seems a misrepresentation of the data. 8) Participants were situated as either living in favourable or unfavourable countries, yet country of location is not mention as a demographic variable collected. Moreover, the abstract says 'birthplace', but there is no argument presented as to why birth country as opposed to country of practice would be the significant predictor 9) The case is never made as why paediatrician attitudes should be uniquely different from healthcare providers more generally. There is plenty of research on healthcare providers (and mental healthcare providers specifically) looking at gender etc differences in attitudes towards trans people. This should be summarised as a point of comparison in the discussion or else a case should be made as to why paediatricians are a unique population likely to have entirely different attitudes (which, based on the findings, is clearly not the case). 10) A clear limitation of the study is that it used the TABS, which is not paediatric in focus. This, to me, really puts the findings in question when framed around the needs of transgender children. In other words, attitudes towards transgender people in general amongst paediatricians and attitudes towards transgender children may well be two different things.

REVIEWER	Daphna Stroumsa University of Michigan, Ann Arbor, MI, USA
REVIEW RETURNED	25-Jun-2019

GENERAL COMMENTS	General Comments: The paper addresses an important topic. I commend the authors for conducting this study. The data are interesting, and help us in gaining further understanding regarding barriers to care that transgender children, youth, and adolescents face. The paper has however several significant conceptual, methodological, analytic and writing issues; many of these can be improved upon with some analytic and/or descriptive adjustments. Others are inherent to the set-up of the study. In the very least, these latter need to be explicitly acknowledged and contended with. The major issues in this paper are as follows: 1. Conceptually: Generally, the paper would be strengthened by a more robust theoretical discussion of the importance of attitudes on health care and health outcomes. What are the implications of individual clinicians' attitudes? Do pediatricians' attitudes affect the

	quality of care received by transgender children? (For example: there is a distinct possibility that even if physicians have conservative sex/gender beliefs, they are able to care well for transgender children; if this is not the case, please state so clearly and provide supportive data. See comment 4e). 2. Methodologically: a. The study appears to have been conducted in a single geographical setting -presumably the country of origin of the authors, though this is not stated. Some explicit discussion could ameliorate this problem. Given that the paper addresses cultural and social issues - what are the ways in which the findings are unique to this setting? How did this setting determine their methodologies? To what extent are the findings from the study generalizable to pediatricians elsewhere? b. The authors selected several demographic variables to analyze. A conceptual model showing the rationale for choosing these particular variables, and leaving out others, as well as hypothesized relationships between these variables and the outcome variables would sharpen both the analysis and the discussion. As an example, how are sex/gender beliefs hypothesized to be affected by seniority, as opposed to age, education, prior exposure, and how was this hypothesis carried through in the analysis? c. Relatedly, while we do not have the full survey instrument available, it appears to be limited to demographics and outcome variables. This inevitably limits more complex analyses of correlates, mediators and moderators of relationships between predictors and outcomes. However, such additional variables should in the very least be hypothesized and acknowledged (for example: prior medical training or educational exposure). d. The concept of birth place as predictor of attitudes is essentialist, as it does not capture the trajectories of immigration, migration, and cultural shifts. It is a very remote and inaccurate measurement of identity/culture, which confounds contemporaneous culture from birth-country culture? To the best of this reviewer's knowledge, it has not been previously validated as a measure of "culture", or as a measure of transphobic attitudes amongst individuals. Additional information regarding the birth countries of study participants (e.g., how many countries in each group?) may be helpful to alleviate some, though not all, concerns raised by this concept e. Similarly, the use of a dichotomous "religious" vs. "secular" variable appears to be culturally unique. It also appears to assume homogeneity in religious (as opposed to religiosity). While both religion and religiosity have previously been associated with attitudes towards LGB and transgender individuals, this gross division needs to be contextualized to enable analysis, and may preclude generalization of findings. f. Please include a description of how participating hospitals and clinics were selected, and how participants were recruited at each site. 3. Analytically: a. the primary outcome was a categorical variable; the authors elected to dichotomize this variable. While they explain the rationale for dichotomization, they could well have used statistical methods intended for nominal variables in their analysis. Additionally, there is no rationale for the particular point at which results were dichotomized, leading to concern as to the significance (clinical / conceptual -not statistical) of their findings. b. Given that participants were selected at particular sites, this raises the question of the need for multilevel analysis at the site level. 4. Writing:

	a. Please ensure consistent use of the term “transgender” as an adjective – not a noun (for example: “Pediatricians’ beliefs regarding transgender people” rather than “towards transgenders”. b. Please define “interns” and “senior” pediatricians. I suspect the authors are referring to pediatricians in training (“resident”, “junior”, or “house officer” – depending on country and terminology) and physicians who have completed training (“attending physician” or “consultant”). c. There is no explanation for the significance of seniority, as opposed to age of respondents. d. Tables: Please add a table with summary descriptive statistics of the respondent population; and an additional table summarizing all variables in multivariable analysis e. Citations: there are a handful of papers that address the relationships between pediatricians and transgender people. Other papers that address other healthcare providers’ attitudes towards transgender patients. Please engage with them in your introduction /discussion, and cite them. (For example: Shires et al., To Refer or Not to Refer: General Pediatricians' Perspectives on Their Role in Caring for Transgender Youth; Stroumsa et al., Transphobia rather than education predicts provider knowledge of transgender health care). These may also assist you in discussing the importance of attitudes and the implications of your findings, see comment #1. f. In your discussion, please address the differences in findings between the human values domain, the interpersonal comfort domain, and the sex/gender beliefs domain.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name: Gary Butler
Institution and Country: UCLH, England
Please state any competing interests or state ‘None declared’: Chair, Gender Dysphoria Working Group, European Society for Paediatric Endocrinology. Clinical lead in endocrinology, National Gender Identity Development Service

This is an interesting and helpful study beginning to unpick reasons for discomfort in dealing with transgender persons. It focused on paediatricians as that was the accessible group, but it may well be interesting to explore other groups. The survey asked about personal beliefs and ideologies but not with the actual influence on clinical practice.
It is a straightforward, honest account of the study performed and the study is well conducted, and the paper is well presented (other than US spelling). Studies like these do help stimulate the debate in this area and highlight the need for better education of doctors.
Reply : We thank the reviewer for his comment. The spelling was changed to British spelling.

I was surprised some of the highly significance values reported in table 1 with identical median values. Please could they be confirmed?
Reply : The data and numbers were inspected and confirmed. Indeed, the numbers in the human value domain column of table 1 were very similar, as almost all the participants scored high in this domain. The human domain examined whether the paediatricians acknowledge transgender persons as human beings regardless of their personal feelings about transgender people. Items such as: "Transgender people are people who deal with their difficulties, just like the rest of us" received a perfect score almost unanimously.

I would be happy with this paper as it stands (with minor clarification to the editor) but paradoxically it

is an editorial decision as to whether the journal wishes to extend the debate in this area. This is an open review so the editor should be aware I published a factual educational article in a BMJ family journal last year (ADC) so this, in my view is complimentary.

Reviewer: 2
Reviewer Name: Professor Damien W Riggs
Institution and Country: Flinders University, Australia
Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below
1) The abstract and introduction require greater nuance. Yes, in general transgender children experience poorer outcomes compared to cisgender peers, but not when they are affirmed in their gender, particularly by families. Recent research by Olson and colleagues has found very similar outcomes for transgender and cisgender young people when the former are affirmed.
Reply : We thank the reviewer for raising this matter. Indeed, the study by Olson strengthens the point that lack of stigma may enable easier transition, and further emphasizes the important role of paediatricians in supporting parents and children. This article is now cited in the manuscript and the point is clarified. (page 4, last paragraph, ref 12)

2) 'Female' and 'male' are sex-based categories: preferable to use 'women' and 'men' throughout.
Reply : We changed the categories to women and men, as appropriate.

Was there no question asking if participants were transgender or cisgender? This seems a significant oversight.
Reply : We did ask the participants about their gender identity. Two participants responded "other". This is clarified on page 8 line 2.

3) There are problems with English expression in the article summary
Reply : The revised manuscript, including the article summary, was edited by a professional English editor.

4) There is a leap in lines 50-57 from poor outcomes (though see 1 above) to pediatricians' role. The two are not automatically or logically connected
Reply : We thank the reviewer for the comment. The paragraph was changed to improve the flow of ideas.

5) The next paragraph then does not follow on: what progress? How does this relate to the previous paragraph?
Reply : The paragraph was changed and corrected.

6) The alpha value for the TABS should be reported in regards to the present study (or better still, for each sub scale)
Reply : Cronbach's alpha for the Humanity subscale was 0.89, for the Sex and gender beliefs subscale 0.87 and for Interpersonal comfort 0.92. These values indicate excellent internal consistency of all the subscales. These data are now presented on page 9.

7) I wasn't convinced by the justification for translating the TABS into a categorical measure. Has this been done before? Having one point as favourable and all other points as unfavourable seems a misrepresentation of the data.
Reply: The participants responded according to a seven-point Likert scale. The data are presented in

Table 1 according to simple sums and averages of the responses. However, the scores are not intuitively captured. Translating TABS into categorical measures facilitates understanding the populations at risk for stigma. Based on the article: "Analyzing and Interpreting Data From Likert-Type Scales", we did not assume that the difference between responses is equidistant even though the numbers assigned to those responses are. We were interested in distinguishing between respondents with acceptable attitudes and those with less than acceptable attitudes. Since we expect a high standard of tolerance from paediatricians, we set a score of 6-7 as acceptable.

8) Participants were situated as either living in favourable or unfavourable countries, yet country of location is not mention as a demographic variable collected. Moreover, the abstract says 'birthplace', but there is no argument presented as to why birth country as opposed to country of practice would be the significant predictor
Reply: We apologize for this inattentiveness. The study was conducted in Israel and all the participants are living in Israel; therefore, this could not be used as a variable. This matter is now clarified in the Methods section, study design and participants, on page 4, as well as in the Title and abstract.

We studied the impact of birthplace as cultural backgrounds have been shown to have an impact on values and beliefs. We did not assess the number of years since immigration to Israel. Notably, immigrants tend to retain certain patterns of their origin culture, due to a desire to preserve their former identity, if only in part, and the need for a sense of continuity, belonging and self-esteem. Indeed, physicians born in transphobic countries felt more uncomfortable regarding transgender persons than did those born in trans-respect countries. This issue is now included in the limitations of the study.

9) The case is never made as why paediatrician attitudes should be uniquely different from healthcare providers more generally. There is plenty of research on healthcare providers (and mental healthcare providers specifically) looking at gender etc differences in attitudes towards trans people. This should be summarised as a point of comparison in the discussion or else a case should be made as to why paediatricians are a unique population likely to have entirely different attitudes (which, based on the findings, is clearly not the case).
Reply: We thank the reviewer for this important suggestion. Although we did find studies on attitudes of psychiatrists, perinatal care providers, providers of pharmaceutical care, emergency medicine residents and oncologists, we did not find studies that assessed attitudes of paediatricians. As mentioned in the introduction, paediatricians are generally the first healthcare worker to see transgender children and their families; they are responsible for referring them to GNRH treatment and should be ready to recognize depression and anxiety. High rates of attempted suicide (30- 50%) are reported among transgender persons. This is now summarized in the discussion, pages 13-14, references (41-47).

10) A clear limitation of the study is that it used the TABS, which is not paediatric in focus. This, to me, really puts the findings in question when framed around the needs of transgender children. In other words, attitudes towards transgender people in general amongst paediatricians and attitudes towards transgender children may well be two different things.
The three-dimensional structure of the TABS enables assessing multiple dimensions of beliefs and attitudes. Therefore, it serves as an effective tool for investigating various subsets of the population including healthcare givers. The advantage conferred from using TABS is that it enables comparison with previous studies and other groups of caregivers.

Reviewer: 3

Reviewer Name: Daphna Stroumsa
Institution and Country: University of Michigan, Ann Arbor, MI, USA
Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below
General Comments:
The paper addresses an important topic. I commend the authors for conducting this study. The data are interesting, and help us in gaining further understanding regarding barriers to care that transgender children, youth, and adolescents face.
Reply: We thank the reviewer for her comment.

The paper has however several significant conceptual, methodological, analytic and writing issues; many of these can be improved upon with some analytic and/or descriptive adjustments. Others are inherent to the set-up of the study. In the very least, these latter need to be explicitly acknowledged and contended with.
The major issues in this paper are as follows:
1. Conceptually: Generally, the paper would be strengthened by a more robust theoretical discussion of the importance of attitudes on health care and health outcomes. What are the implications of individual clinicians' attitudes? Do pediatricians' attitudes affect the quality of care received by transgender children? (For example: there is a distinct possibility that even if physicians have conservative sex/gender beliefs, they are able to care well for transgender children; if this is not the case, please state so clearly and provide supportive data. See comment 4e).
Reply : We thank the reviewer for this suggestion.
In a survey of 6,450 transgender and gender non-conforming people in the US, discrimination by medical providers was reported. Twenty-four percent proclaimed they were denied equal treatment in doctors' offices and hospitals and 28% reported verbal harassment in a doctor's office, emergency room or other medical setting.
The greatest barriers to healthcare reported by transgender individuals are lack of providers who are sufficiently knowledgeable on the topic, discrimination and lack of cultural competence by providers. A study reported that due to discrimination and disrespect, 28% of adults who identified as transgender persons postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not seek preventive health care. [ref 41 Grant JM, Mottet L, Tanis JE, et al. Injustice at every turn : a report of the National Transgender Discrimination Survey. Secondary Injustice at every turn : a report of the National Transgender Discrimination Survey 2011].

Only a limited number of studies investigated perceived barriers to care among transgender children and adolescents. Transgender youth aged 14- 22 years described judgmental and hostile clinical interactions, inadequate knowledge and the use of outdated offensive language that detracted from providers' ability to deliver gender-affirming care. (pages 13-14).

Physicians' stigma has long been established as a factor that can affect healthcare, and even reduce intention to treat. We state this clearly on page 15, last paragraph with cited references (ref 49,50).

2. Methodologically:
a. The study appears to have been conducted in a single geographical setting -presumably the country of origin of the authors, though this is not stated. Some explicit discussion could ameliorate this problem. Given that the paper addresses cultural and social issues - what are the ways in which the findings are unique to this setting? How did this setting determine their methodologies? To what extent are the findings from the study generalizable to pediatricians elsewhere?
Reply : Indeed the study was conducted in Israel, this is now clarified in the title, the title, abstract and on page 4. As Israel is a country of immigrants, we were able to examine the impact of birthplace on attitudes. Based on the literature regarding attitudes towards transgender people from other places in

the world and based on our findings that males and religious participants had less favourable attitudes, we believe that our findings can be generalized. “We now added to the Discussion, a reference to a systematic review that reported evidence of a consistent association of self-religious identification with more negative attitudes toward transgender people and higher levels of transphobia. Our findings concur with those findings. We hope that the publication of the current study will encourage researchers from other countries to conduct studies that investigate attitudes, such that data can be compared.

b. The authors selected several demographic variables to analyze. A conceptual model showing the rationale for choosing these particular variables, and leaving out others, as well as hypothesized relationships between these variables and the outcome variables would sharpen both the analysis and the discussion. As an example, how are sex/gender beliefs hypothesized to be affected by seniority, as opposed to age, education, prior exposure, and how was this hypothesis carried through in the analysis?
Reply:. Based on previous studies done on abortion, and on attitudes toward lesbian, gay and bisexual people, we hypothesized that stigmatizing attitudes will be expressed more strongly among paediatricians who are men, religious and older, and among those who were raised in conservative cultures. We added a diagram that depicts a conceptual model, as Figure 1.

c. Relatedly, while we do not have the full survey instrument available, it appears to be limited to demographics and outcome variables. This inevitably limits more complex analyses of correlates, mediators and moderators of relationships between predictors and outcomes. However, such additional variables should in the very least be hypothesized and acknowledged (for example: prior medical training or educational exposure).
Reply : We thank the reviewer for this comment. This is now mentioned in the limitations of the study, page 15.

d. The concept of birth place as predictor of attitudes is essentialist, as it does not capture the trajectories of immigration, migration, and cultural shifts. It is a very remote and inaccurate measurement of identity/culture, which confounds contemporaneous culture from birth-country culture? To the best of this reviewer’s knowledge, it has not been previously validated as a measure of “culture”, or as a measure of transphobic attitudes amongst individuals. Additional information regarding the birth countries of study participants (e.g., how many countries in each group?) may be helpful to alleviate some, though not all, concerns raised by this concept
Reply: All the responders live in Israel. Unfortunately, we do not have data on the number of years since their immigration to Israel. However, immigrants tend to retain certain patterns of their old culture, due to a desire to preserve their former identity, if only in part, and the need for a sense of continuity, belonging and self-esteem. This point in discussed in the limitations of the study on page 15.

e. Similarly, the use of a dichotomous “religious” vs. “secular” variable appears to be culturally unique. It also appears to assume homogeneity in religious (as opposed to religiosity). While both religion and religiosity have previously been associated with attitudes towards LGB and transgender individuals, this gross division needs to be contextualized to enable analysis, and may preclude generalization of findings.
Reply : We agree there is great variability in the definition of “religious”. In the current study, people identified themselves as secular vs religious. Those who identified themselves as religious expressed more stigmatization. This point is now discussed on page 12.

f. Please include a description of how participating hospitals and clinics were selected, and how

participants were recruited at each site.
Reply: Participants were approached randomly at two semi-annual paediatric assemblies. This enabled participation of physicians from all over Israel. In addition, the researchers approached physicians at morning grand-rounds in seven hospitals in the center of Israel. These hospitals and the five community clinics were selected due to their convenience.

3. Analytically:
a. the primary outcome was a categorical variable; the authors elected to dichotomize this variable. While they explain the rationale for dichotomization, they could well have used statistical methods intended for nominal variables in their analysis. Additionally, there is no rationale for the particular point at which results were dichotomized, leading to concern as to the significance (clinical / conceptual -not statistical) of their findings.
Reply: The participants responded according to a seven-point Likert scale. The data are presented in Table 1 according to simple sums and averages of the responses. We were interested in distinguishing between respondents with acceptable attitudes and those with less than acceptable attitudes. Since we expect a high standard of tolerance from paediatricians, we set a score of 6-7 as acceptable.

b. Given that participants were selected at particular sites, this raises the question of the need for multilevel analysis at the site level.
Reply: As detailed in the section on the study design and participants, paediatricians were approached randomly at two semi-annual paediatric assemblies. This approach ensured participation of physicians from all over the country. Paediatricians were identified according to their national identity numbers. However, since their affiliation to specific hospitals was not recorded, the analysis suggested cannot be done.

4. Writing:
a. Please ensure consistent use of the term “transgender” as an adjective – not a noun (for example: “Pediatricians’ beliefs regarding transgender people” rather than “towards transgenders”.
Reply : This was corrected throughout the study

b. Please define “interns” and “senior” pediatricians. I suspect the authors are referring to pediatricians in training (“resident”, “junior”, or “house officer” – depending on country and terminology) and physicians who have completed training (“attending physician” or
Reply : In the revised manuscript, we used the terms “residents” and “senior paediatricians”. We defined in the Methods section on page 6, a resident as a physician who is under postgraduate training in the field of paediatrics. A senior pediatrician is a physician who passed the postgraduate examinations in paediatrics.

c. There is no explanation for the significance of seniority, as opposed to age of respondents.
Reply: Seniority and age were highly correlated. Our rationale for choosing seniority vs age lies in the fact that we were interested in identifying the paediatricians who may benefit from educational programs.

d. Tables: Please add a table with summary descriptive statistics of the respondent population; and an additional table summarizing all variables in multivariable analysis.
Reply: As the number of tables and illustration in limited to 5, we inserted the summary of descriptive statistics of the respondent population in the text. Similarly, the variables in multivariable analysis were added in the bottom of table 3.

e. Citations: there are a handful of papers that address the relationships between pediatricians and transgender people. Other papers that address other healthcare providers' attitudes towards transgender patients. Please engage with them in your introduction /discussion, and cite them. (For example: Shires et al., To Refer or Not to Refer: General Pediatricians' Perspectives on Their Role in Caring for Transgender Youth; Stroumsa et al., Transphobia rather than education predicts provider knowledge of transgender health care). These may also assist you in discussing the importance of attitudes and the implications of your findings, see comment #1.
Reply : We thank the reviewer for the suggestions and we expanded the reference list.

f. In your discussion, please address the differences in findings between the human values domain, the interpersonal comfort domain, and the sex/gender beliefs domain.
This is addressed in the summary of the discussion.

VERSION 2 – REVIEW

REVIEWER	Gary Butler UCLH UCL GOS ICH
REVIEW RETURNED	27-Aug-2019

GENERAL COMMENTS	This is a revision, having seen and reviewed the original paper. Unfortunately the reviewing tool system does not let me see my earlier comments, but I have been through this revised paper. It is an honest open report. It is pertinent to the study country but international corollaries can be inferred if not deducted. It contributes to the debate, opens a source of reflection into our practice, so that to me is a valuable take home message, despite it being a survey rather than primary research. It is an editorial decision but I believe it is thought provoking.

REVIEWER	Professor Damien Riggs Flinders University, Australia
REVIEW RETURNED	21-Aug-2019

GENERAL COMMENTS	The authors have done a good job of revising the paper. Two issues, however, remain outstanding: 1) I accept that the TABS is a standardised measure, but has it ever been used to examine attitudes towards children before? I say this again as the authors have measured attitudes towards transgender *people*, presuming that attitudes towards transgender *children* will be the same. Certainly, pediatricians may see a small number of transgender parents, but primarily here the focus is on paediatricians seeing transgender children. At the very least it should be acknowledged in the limitations that the TABS does not focus on children and the most we know from the study is how the sample feel about transgender people as a general category, which may say nothing at all about how they feel about, and would treat, transgender children 2) On a related note, the authors still havent given an explanation of why we would expect the attitudes of pediatricians to differ from other healthcare professionals. The authors have now clarified *why* the attitudes of pediatricians are so important, but there is nothing to say why we would expect pediatricians to have attitudes specific to their profession (and it would seem from the results that

	they dont). This point is important as at present the authors ignore a great range of publications on healthcare professional attitudes. The authors could easily cite one of a number of systematic reviews on the topic (and their key findings) to acknowledge that pediatricians are likely to have similar attitudes. For example: https://www.tandfonline.com/doi/abs/10.1080/15532739.2017.1374227

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2
Reviewer Name: Professor Damien Riggs
Institution and Country: Flinders University, Australia
Please state any competing interests or state 'None declared': None declared

The authors have done a good job of revising the paper.
We thank Professor Riggs for this comment.

Two issues, however, remain outstanding:

1) I accept that the TABS is a standardised measure, but has it ever been used to examine attitudes towards children before? I say this again as the authors have measured attitudes towards transgender *people*, presuming that attitudes towards transgender *children* will be the same. Certainly, pediatricians may see a small number of transgender parents, but primarily here the focus is on paediatricians seeing transgender children. At the very least it should be acknowledged in the limitations that the TABS does not focus on children and the most we know from the study is how the sample feel about transgender people as a general category, which may say nothing at all about how they feel about, and would treat, transgender children

We agree with the reviewer's comment that pediatricians may see a small number of transgender children. However, pediatricians are exposed to transgender children and adolescents in the media, in their neighborhoods, and thus they may form an opinion and be trans-respect or transphobic. Furthermore, "transgender people" is an accepted terminology – regardless of age.
Nevertheless, we understand the reviewer's point of view, and we added to the limitations of the study page 15, first paragraph an acknowledgement that the TABS does not necessarily focus on children and that the most we know from the study is how the respondents feel about transgender people as a general category.

2) On a related note, the authors still havent given an explanation of why we would expect the attitudes of pediatricians to differ from other healthcare professionals. The authors have now clarified *why* the attitudes of pediatricians are so important, but there is nothing to say why we would expect pediatricians to have attitudes specific to their profession (and it would seem from the results that they dont). This point is important as at present the authors ignore a great range of publications on healthcare professional attitudes. The authors could easily cite one of a number of systematic reviews on the topic (and their key findings) to acknowledge that pediatricians are likely to have similar attitudes. For example: https://www.tandfonline.com/doi/abs/10.1080/15532739.2017.1374227

We thank the reviewer for the helpful suggestion. We added in the discussion that other healthcare professional showed similar attitudes [page 13 paragraph 2]:

While one-third of all transgender individuals who had seen a health care professional in the past year reported being harassed or denied care, less is known about transgender care from the physician's perspective. Among primary care clinicians and gynaecologic health care providers, 15-30% expressed not feeling capable of providing care to transgender patients {Shires, 2018 [1]}{Shires, 2019 2}. This is the first study among paediatricians.

1 Ann Fam Med. 2018 Nov;16(6):555-558. doi: 10.1370/afm.2298. Primary Care Clinicians' Willingness to Care<="" span="" style="font-family: "Times New Roman";">Transgender Patients.
Shires DA[1,2], Stroumsa D[3], Jaffee KD[4], Woodford MR[5].

2 J Womens Health (Larchmt). 2019 Aug 14. doi: 10.1089/jwh.2018.7384. [Epub ahead of print]Gynecologic Health Care Providers' Willingness to Provide Routine Care and Papanicolaou Tests for Transmasculine Individuals.
Shires DA[1], Prieto L[1], Woodford MR[2], Jaffee KD[3], Stroumsa D[4].

Reviewer: 1
Reviewer Name: Gary Butler
Institution and Country: UCLH, UCL GOS ICH

This is a revision, having seen and reviewed the original paper. Unfortunately the reviewing tool system does not let me see my earlier comments, but I have been through this revised paper. It is an honest open report. It is pertinent to the study country but international corollaries can be inferred if not deducted. It contributes to the debate, opens a source of reflection into our practice, so that to me is a valuable take home message, despite it being a survey rather than primary research. It is an editorial decision but I believe it is thought provoke

We thank Professor Butler.

VERSION 3 – REVIEW

REVIEWER	Damien Riggs Flinders University, Australia
REVIEW RETURNED	06-Dec-2019

GENERAL COMMENTS	Thank you for making these final revisions. It is an excellent paper.